BILL LOCKYER
Attorney General of the State of California
DOUGLAS M. PRESS
Supervising Deputy Attorney General
GEORGE PRINCE, State Bar No. 133877
Deputy Attorney General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5749
Fax: (415) 703-5480

Attorneys for Respondents Sandra Shewry, in her Official Capacity as Director of the California Department of Health Services; and California Department of Health Services

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SAN FRANCISCO

KEVIN CONLAN, ASHER SCHWARZMER and THOMAS STEVENS,

Petitioners,

v.

SANDRA SHEWRY, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH SERVICES; CALIFORNIA DEPARTMENT OF HEALTH SERVICES, et al.,

Respondents.

Case No. 987 697

RESPONDENTS' REPLY TO PETITIONERS' REMAINING OBJECTIONS TO RESPONDENTS' REVISED PLAN AND NOTICE

Hearing Date: November 9, 2006
Time: 9:30 a.m.
Dept. 301

INTRODUCTION

As petitioners note in the introduction to their October 19, 2006 filing, "Petitioners' Remaining Objections to Revised Plan and Notice" (Remaining Objections), the parties' negotiations have resulted in agreement on all but two issues as to the California Department of Health Services'(CDHS) Revised Plan for Beneficiary Reimbursement (Plan). CDHS submits that those two remaining issues -- involving the type of documentation beneficiaries can submit

to support their claims for reimbursement, and the use of declarations in the reimbursement process -- have now been resolved by additional revisions to CDHS's Plan.

1. The "Prescriptions, Orders, or Notes" Limitation Has Been Removed.

The first of petitioners' remaining objections was with that portion of the revised Plan's criteria for processing a beneficiary claim requiring submission of a physician or health care provider's note, order or prescription for the specific service for which reimbursement was sought. That criteria was reflected on the last proposed notice to beneficiary by the statement, "You have a prescription, order or note from the medical or dental provider, or a county In-Home Supportive Services needs assessment for the medical or dental service you received and for which you paid (except for a doctor/dentist office visits, which does not require a prescription)[.]" (Remaining Objections, 1:18-2:2.)

That limiting language has been removed from the Plan. In the latest revision to the Plan, the section setting forth CDHS's "Criteria For Processing Beneficiary Claims" now includes the following provisions, at bullet points five and seven, respectively, of the Plan:[1/]

> "The beneficiary has submitted a valid claim which includes dated proof of payment by the beneficiary or another person on behalf of the beneficiary, for the service(s) received (cancelled check, provider receipts, etc.), with an itemized list of services covered by the payment, and to whom the payment was made;" and
>
> "For those Medi-Cal services that would have required Medi-Cal authorization, the beneficiary has documentation from the medical or dental provider that shows medical necessity for the services(s);"

---

1. Petitioners' counsel have been provided, separately from this filing, with electronic copies of the revised Plan and notice to beneficiaries in both "clean" (i.e., the revised form) and "track change" (i.e., allowing comparisons of the current and previous versions) formats for review.

(Exhibit A, Revised Plan for Beneficiary Reimbursement, at p. 8, section F, fifth and seventh bullet points.)

The first provision (bullet point five) replaces the previous requirement in the Plan of which petitioners complained – "There is a physician or health care provider (within his/her scope of practice) order or prescription for the specific service(s) (except for a physician or dentist office visit, which does not require a prescription;" (Exhibit 1 to Remaining Objections, p. 8, section F, bullet point four). The use of the word "documentation" in the second provision (bullet point seven) makes clear the removal of the narrowing language altogether from the criteria.[2/]

In step with this change to the Plan, the "prescription, order or note" reference has also been removed from the notice to beneficiaries. (Exhibit B, proposed notice to beneficiaries, p. 1.) In the previous version of the notice, the fourth enumerated point read: "You have a prescription, order or note from the medical or dental provider, or a county In-Home Supportive Services needs assessment for the medical or dental service you received and for which you paid (except for a doctor/dentist office visits, which does not require a prescription), and". (See at Exhibit 2 to Remaining Objections, line item 4). That limiting language has been removed from the proposed notice to beneficiaries altogether.

The new version of the notice states: "For those Medi-Cal services that were provided and would have required Medi-Cal authorization, you have documentation from the medical or dental provider that shows medical necessity for the service, and ". (Exhibit B, p. 1, line item 4.) Use of the word "documentation" here addresses, and should put to rest, petitioners' concerns about limitations as to what type of documentary materials a beneficiary can submit in support of the medical necessity showing required for some reimbursement claims.

---

2. With this revision, the context of the remainder of the "Criteria For Processing Beneficiary Claims" is now clearer as to the difference between documentation sufficient to prove medical necessity and documentation allowable for meeting other criteria -- such as dates of services, amounts paid, and eligibility -- that are distinct from "medical necessity."

2. The Use of Declarations for Some Purposes is Now Permissible Under the Plan.

Petitioners' second remaining objection to the Plan was as to its disallowance of the use of declarations in the claims process. (Remaining Objections, pp. 5-6, referring to the previous Plan's statement that "Declarations/certifications are not acceptable as documentation to meet the criteria.") That concern has also been addressed by the revised Plan by the removal from the Plan of the categorical disallowance. The Plan now recognizes the possible use of declarations for all but the showing of medical necessity. In fact, the Plan now expressly states, in the same paragraph where the disallowance had been stated, that

> "Claims must meet the following criteria in order to qualify for reimbursement. In some cases to satisfy the criteria a declaration might supplement other documentary evidence. A declaration shall not substitute for documentation of medical necessity."

(Exhibit A, p. 8, first paragraph under "Criteria for Processing Beneficiary Claims".)

This revised provision expressly recognizes the potential value of declaratory testimony and allows for its consideration in most contexts, while retaining the legitimate requirement that a declaration cannot substitute for documentation of medical necessity.

CONCLUSION

For the reasons stated above, respondents respectfully submit that petitioners' concerns with the Plan and notice to beneficiaries have been addressed in full.

Dated: October 27, 2006

Respectfully submitted,

BILL LOCKYER
Attorney General of the State of California

DOUGLAS M. PRESS
Supervising Deputy Attorney General

GEORGE PRINCE
Deputy Attorney General

Attorneys for Respondents

EXHIBIT A

California Department of Health Services' Revised Plan for Beneficiary Reimbursement *Conlan v. Bontá; Conlan v. Shewry*

A. Procedural History/Background

Petitioners initiated the lawsuit entitled *Conlan v. Bontá* in June 1997. Following a ruling where the trial court denied the petition for writ in its entirety, the Court of Appeal reversed the trial court's decision in *Conlan v. Bontá* (2002) 102 Cal.App.4th 745 (*Conlan I*). In *Conlan I*, the court held that under 42 U.S.C. section 1396a(a)(10)(B) (the "comparability provision") the California Department of Health Services (Department) was required to implement a process by which Medi-Cal beneficiaries may obtain prompt reimbursement for covered services for which they paid during the three months prior to applying for Medi-Cal coverage (the "retroactivity period").

Following the issuance of *Conlan I*, the Department submitted a proposed Compliance Plan (Plan) to the trial court. Petitioners objected to several of the Plan's key provisions. The trial court found for the petitioners on all issues and concluded that the provisions were invalid. The trial court refused to approve the Department's Plan without modification to the Plan's disputed provisions. The Department appealed from that order.

On August 15, 2005, the California Court of Appeal issued its decision in the case of *Conlan v. Shewry* (2005) 131 Cal.App.4th 1354 (*Conlan II*).

In *Conlan II*, the Court of Appeal addressed five key issues relevant to the Plan's implementation. The court dismissed the Department's position that the trial court's ruling was (among other things) in conflict with California law (see Welfare and Institutions Code section 14019.3), in conflict with specific instructions from the Centers for Medicare and Medicaid Services (CMS) regarding this case (November 17, 2003 letter from CMS), and an invitation to fraud and abuse of the Medi-Cal Program. Ultimately, the court held that the Department is required to:

(1) Send notice of the new monetary reimbursement process available to all current and former Medi-Cal beneficiaries who may have claims arising on or after June 27, 1997;

(2) Provide monetary reimbursement to any individual who has a valid claim for reimbursement arising on or after June 27, 1997;

(3) Provide reimbursement for valid claims arising from the date an application for Medi-Cal eligibility is submitted to the date that the application is granted (the "evaluation period");

(4) Provide reimbursement for services rendered by non-Medi-Cal providers if the services were provided during the retroactivity period (the Department is not required to provide reimbursement for services rendered by non-Medi-Cal providers during the evaluation period); and

(5) For valid claims, reimburse the beneficiary the amount paid, not to exceed the rate established for that service under the Medi-Cal program.

Following the issuance of *Conlan II*, the Department again submitted a proposed Plan to the trial court. In response, petitioners objected to six of the Plan's key provisions.

On February 8, 2006, the trial court found for the petitioners on four of the six issues presented, including three issues to which the Department had previously stipulated to resolve as demanded by the petitioners. Most notably, the court found that Welfare and Institutions Code, section 14019.3(g), required the Department to implement an enforcement action in order to "aggressively encourage" providers to cooperate in reimbursing beneficiary claims for reimbursement.[1] To comply with this order, the Department proposes in this Revised Plan for Beneficiary Reimbursement (Revised Plan) for court approval of the enforcement action entitled "Recoupment" by which the Department will permanently divert expected payments from a Medi-Cal provider in order to reimburse the beneficiary's valid claim.

The trial court also found that the issue regarding reimbursement of post approval expenses was not ripe for decision. The court stated it would decide "whether and the extent to which post-eligible reimbursement shall be made to beneficiaries" at a future hearing following a noticed motion and full briefing.

At the further hearing held on May 4, 2006, the trial court found for the petitioners regarding reimbursement of post approval expenses. The court directed the Department to expand the scope of post approval reimbursement, specifically invalidating a portion of Welfare and Institutions Code, section 14019.3(a)(1) that limits post approval claims for reimbursement to excess co-payments. The court issued its written order on May 18, 2006.

B. Policies/Steps Implemented

[1] "The Court hereby directs the Department to develop a more proactive provider reimbursement scheme, one that aggressively encourages voluntary provider compliance. That scheme shall set forth the specific steps the Department will take to 'ensure' voluntary compliance (W&I Code section 14019.3(h)), as well as the enforcement action the Department will follow if its voluntary compliance efforts are not successful (W&I Code section 14019.3(g)). To put the Court's expectations more directly, albeit in a somewhat colloquial manner: 'Let's see some teeth here.'" (Trial court's order, February 8, 2006: page 4, lines 11-18.)

As a result of the trial court's February 8 and May 18, 2006 orders, the Department initiated and/or completed the following steps:

- Identified and developed a process for taking action to recoup beneficiary out-of-pocket payments made to Medi-Cal providers after which a Medi-Cal provider can submit a claim to Medi-Cal for reimbursement at the Medi-Cal rate for the Medi-Cal covered service provided. (Addresses the February 8, 2006 trial court order, Issue 1.)

- Established a new State Hearing procedure expanding the current Department of Social Services' (DSS) State Hearing process to specifically address Medi-Cal provider appeals from proposed recoupment actions. This new procedure will include Medi-Cal providers in the State Hearing when they object to a proposed recoupment by the Department on behalf of the claiming beneficiary. To accomplish this expanded procedure, the Department:

    - Met with DSS weekly to identify changes to the current process,

    - Developed procedures specifying steps to be taken in processing State Hearing requests,

    - Reviewed current legal authority for the State Hearing process,

    - Identified necessary changes to legal authority in order to implement the new State Hearing procedure. (Addresses the February 8, 2006 trial court order, Issue 1.)

- Developed a notice of action (NOA) that includes a State Hearing request form for beneficiary and Medi-Cal provider requests for a State Hearing involving reimbursement process requests. (Addresses the February 8, 2006 trial court order, Issue 1.)

- Expanded the Plan and Beneficiary Notice to reflect inclusion of beneficiary reimbursement for excess share of cost payments and other Medi-Cal covered services for which the beneficiary paid after Medi-Cal eligibility was determined. (Addresses the February 8, 2006 trial court order, Issue 2; and the May 18, 2006 trial court order.)

- Directed DSS to send a copy of all beneficiary reimbursement State Hearing decisions to the Department. The Department will process with the decision without further action from the beneficiary. (Addresses the February 8, 2006 trial court order, Issue 3.)

- Revised the Plan to reflect the 90-day timeframe for filing claims after the beneficiary is issued their Medi-Cal card. (Addresses the February 8, 2006 trial court order, Issue 4.)

- Developed an enclosure in nine additional languages to include with the Beneficiary Notice. The enclosure advises beneficiaries to call the Beneficiary Service Center telephone number if they need the notice translated in their language. (Addresses the February 8, 2006 trial court order, Issue 5.)

- Developed a Beneficiary Reimbursement Claim Form for submission by a beneficiary requesting reimbursement of out-of-pocket payments for Medi-Cal covered services.

- Updated the Medi-Cal beneficiary information booklet and application forms reminding Medi-Cal applicants that they need to utilize Medi-Cal providers when they receive Medi-Cal covered services in order to be reimbursed by Medi-Cal.

- Coordinated meetings with other State departments and agencies regarding implementation and expectations regarding the new reimbursement process.

- Revised reimbursement process notification template letters to be used during the claims adjudication process.

C. Implementation

This Plan will be implemented to the extent that Federal Financial Participation funding is available.

The Department will adjudicate completed claims for reimbursement (usually within approximately 120 days of receipt of the beneficiary's completed claim) of Medi-Cal covered services expenses incurred and paid during the retroactive period (up to 3 months prior to the time of application), during the evaluation period (from the time of application to the Medi-Cal program until the issuance of the beneficiary's Medi-Cal card), and in the post-approval period (the time period after issuance of the beneficiary's Medi-Cal card). In addition, when it is appropriate and Medi-Cal providers cooperate or funds are available from a Medi-Cal provider for recoupment,[2] beneficiary reimbursement will be for the beneficiary's full payment of out-of-pocket expenses. This includes amounts above the Medi-Cal rate for Medi-Cal covered services.

With court approval of this Revised Plan, the method of reimbursement will include: "cooperative" payments by providers; "recoupment" actions against uncooperative

[2] Whether the recoupment process is appropriate will be determined by the department or program reviewing the claim for final adjudication and/or payment. If recoupment is not appropriate, then the involved department will reimburse the beneficiary directly for the valid claim at the amount paid, not to exceed the rate established for the service under the Medi-Cal program.

Medi-Cal providers, as more fully set forth below; and, when necessary, direct reimbursement to the beneficiary from the Department up to the current Medi-Cal rate for the applicable Medi-Cal covered services.

D. Beneficiary Notice

Upon court approval of this Revised Plan and the Beneficiary Notice, the Department will begin the process of mailing the Beneficiary Notice to the address of record of all current beneficiaries, as well as those individuals who were eligible at any time since June 27, 1997. This Beneficiary Notice is attached to the Revised Plan. The Beneficiary Notice will be sent to an estimated 11 million households. The cost of mailing this notice exceeds $3,000,000.

The Beneficiary Notice will be printed in English and Spanish and will be accompanied by a separate enclosure in which the following is printed in nine additional languages spoken by the largest number of non-English speaking beneficiaries in California:

> "REQUEST FOR NOTICE IN OTHER LANGUAGES
>
> If you were eligible for Medi-Cal anytime since June 27, 1997, or are eligible now, Medi-Cal may reimburse you for medical or dental bills that you paid. This notice tells you how to get more information. If you need this information in (insert appropriate language), please call (916) 403-2007." (Addresses February 8, 2006 court order, Issue 5.)

Telephone operators dedicated to the reimbursement process will be available to assist beneficiaries in translating their notice from English/Spanish to the nine (9) additional languages.

The printing and mailing of the Beneficiary Notices is dependent upon and will follow court approval. This Beneficiary Notice mailing activity will begin upon receipt of the court's approval of the Revised Plan. It will take several weeks to complete the mailing of all Beneficiary Notices to an estimated 11 million Medi-Cal households.

Medi-Cal providers will be sent additional and periodic bulletins to notify them of this reimbursement process and to remind them of their responsibilities to promptly reimburse beneficiaries who may have paid out-of-pocket expenses for Medi-Cal covered services.

E. Process of Beneficiary Claim Review/Adjudication

The process of beneficiary claims review/adjudication includes the following elements and approximate timelines (calendar days):

- Prior to receipt of a complete beneficiary claim:

  The beneficiary may contact the Department's Beneficiary Service Center (which will be dedicated specifically to the new beneficiary reimbursement process and staffed by 40 telephone operators and correspondence staff at implementation) by mail or by phone. At the time of contact, the beneficiary will be directed to the appropriate staff (medical, dental, etc.) and will receive information on what is required in order to properly submit a complete claim and for the involved department or program to approve claims for reimbursement. The Department has developed a standardized claim form with directions on how to complete the form that can be mailed to the beneficiary at the time of initial contact and upon request. As a first step, the Department will mail a claim packet to the beneficiary and the beneficiary will be directed to mail the completed claim packet which includes: the Beneficiary Reimbursement Claim Form with beneficiary information, a completed STD 204 form; a summary itemizing the covered expense(s) for which the beneficiary paid including proof of payment that shows receipt and payment of a service(s) (in some cases a declaration might supplement other documentary evidence); a copy of his/her Medi-Cal Beneficiary Identification Card (BIC); the dates of service(s); the provider'(s) name(s) with address(es) and phone number(s) if known; and for those Medi-Cal services that would have required Medi-Cal authorization, documentation from the medical or dental provider that shows medical necessity for the service.

For CDHS fee for service claims:

- Day 1 – The beneficiary's completed claim is received by the Department;

- Day 2 to 15 –

  1. Redistribute the completed claims to other involved departments or programs for adjudication when the claim, depending upon claim/service type, involves services administered outside of the Medi-Cal fee-for-service program (the adjudication timeline will begin anew from the date the other department or program receives the completed claim, as listed in "Day 1" above)[3]; or

  2. The Department will acknowledge receipt of the beneficiary's claim in writing.

- By Day 15 from receipt of the beneficiary's completed claim the Department will either:

  1. Notify the beneficiary in writing that the claim has been denied. The written notice will include an explanation of the reason(s) for denial based upon the information submitted and a NOA explaining their hearing right and procedure to request a State Hearing,

[3] Redistribution to other involved departments or programs may delay the initial adjudication of a claim and subsequent notifications.

2. Notify the beneficiary that additional information is required in order to process the claim, or

3. Contact the healthcare provider by letter and request full reimbursement for the beneficiary. If the healthcare provider is a Medi-Cal provider and it is determined that the funds are recoupable, the letter will state the Department's intention to initiate the recoupment action against the Medi-Cal provider if the beneficiary is not promptly reimbursed. The Medi-Cal provider will be given 30 days from the date of the letter to comply with the request and provide written confirmation of the reimbursement to the beneficiary or to request a State Hearing.
   Note: If the Medi-Cal provider requests a State Hearing regarding the reimbursement decision or recoupment process, the request will be forwarded to the DSS/State Hearings Division (SHD) along with information that identifies both the Medi-Cal provider and the beneficiary who requested the reimbursement at issue in the State Hearing;

- Day 16 to 60 – The Department will evaluate the healthcare provider's response to the Department's request for direct reimbursement to the beneficiary and continue processing the beneficiary's claim. If additional information is required, the claim is not complete and the reimbursement process may be delayed;

- Day 60 to 120 –

    - If reimbursement for the full amount has been made to the beneficiary by the healthcare provider(s) voluntarily, the Department will close the claim and send a letter to the beneficiary indicating that the claim was closed due to payment from the healthcare provider.

    - If the Medi-Cal provider has not made full reimbursement, the Department will initiate recoupment from the Medi-Cal provider if appropriate.[4]

        - If recoupment is appropriate, then the Department will notify the Medi-Cal provider that the Department will initiate recoupment proceedings against the Medi-Cal provider. The Department will permanently divert funds from the Medi-Cal provider sufficient to reimburse the claim in full, reimburse the beneficiary, and close the claim. The recoupment action will delay the reimbursement process timeline.

[4] Sufficient funds must be available to be permanently diverted from the enrolled provider's expected Medi-Cal payments at the time recoupment is initiated by the Department. If funds are not available from a provider for recoupment, then the Department will directly reimburse the beneficiary for the valid claim at the amount paid, not to exceed the rate established for the service under the Medi-Cal program. (California Welfare and Institutions Code, section 14019.3(i)(5).)

- If recoupment is not appropriate, the Department will directly reimburse the beneficiary for those services approved on the beneficiary's claim. Reimbursement may be up to the allowable Medi-Cal rate(s) for the specific Medi-Cal covered service(s), and shall be considered payment in full of the claim. The Department will also send a letter to the beneficiary indicating that the claim was paid along with pertinent claim payment information and information on requesting a State Hearing.

- If all or part of the beneficiary's claim is denied, the beneficiary will be sent a NOA explaining what was denied and why. The NOA will provide information on how to file for a State Hearing. The beneficiary has 90 days from the date of the NOA to request a State Hearing.

F. Criteria for Processing Beneficiary Claims

Claims must meet the following criteria in order to qualify for reimbursement. In some cases to satisfy the criteria a declaration might supplement other documentary evidence. A declaration shall not substitute for documentation of medical necessity: Claims that do not meet the following criteria will be denied:

- The beneficiary was eligible for Medi-Cal at the time the service(s) was(were) provided;

- The claimed service(s) was(were) provided on or after June 27, 1997;

- The service(s) provided was(were) a Medi-Cal covered service—i.e., a Medi-Cal benefit at the time the service(s) was(were) rendered;

- The beneficiary was eligible to receive the service(s) at the time the service(s) was(were) rendered. Reimbursement to beneficiaries with restricted benefits will be available only for those specific restricted Medi-Cal benefits;

- The beneficiary has submitted a valid claim which includes dated proof of payment by the beneficiary or another person on behalf of the beneficiary, for the service(s) received (cancelled check, provider receipts, etc.), with an itemized list of services covered by the payment, and to whom the payment was made;

- The beneficiary has submitted a completed STD 204 form;

- For those Medi-Cal services that would have required Medi-Cal authorization, the beneficiary has documentation from the medical or dental provider that shows medical necessity for the service(s);

- The claimed cost(s) was(were) not required to meet co-payments, share of cost or other cost-sharing requirement(s);

- The beneficiary was not previously reimbursed for the claimed service(s) by Medi-Cal/Denti-Cal, other Medi-Cal funded program, the healthcare provider or by a third party;

- The beneficiary did not have other health coverage at the time the service(s) was(were) rendered that would have been obligated to pay the claimed cost(s);

Claims for Medi-Cal covered service(s) provided during the evaluation period for date(s) of service on or after February 2, 2006, and claims for Medi-Cal covered service(s) provided during the post approval period for date(s) of service on or after June 27, 1997, the service(s) must have been rendered by a provider who at the time the service(s) was(were) rendered was an active Medi-Cal authorized provider.

Submission timelines for a timely claim:

- The claim(s) for service(s) that was(were) provided from June 27, 1997, through Month Day, Year[D1], must be received by the Department by Month Day, Year [D2], or within 90 days after issuance of the Medi-Cal card (addresses the February 8, 2006 trial court order, Issue 4), whichever is the longest period of time (to account for those claims in which the beneficiary's evaluation period was longer than a calendar year);

- The claim(s) for service(s) that was(were) provided on or after Month Day, Year[D3], must be received by the Department within one calendar year after the date the service(s) was(were) rendered or within 90 days after issuance of the Medi-Cal card, whichever is the longest period of time (to account for those claims in which the beneficiary's evaluation period was longer than a calendar year) (Addresses the February 8, 2006 trial court order, Issue 4);

- If either a State Hearing request or a claim was timely submitted and must be dismissed for a defect that can be cured, the Administrative Law Judge (ALJ) will refer the beneficiary back to the Department for evaluation of the claim. The ALJ's order will provide that the beneficiary may file a new or amended claim with the Department within 60 days after the issuance date of the ALJ's written dismissal decision, if the period for filing the claim is past, or within any period remaining to file a timely or amended claim, if that period is longer.

G. State Hearings- New Procedures

There are two claims adjudication outcomes that will lead to a new State Hearing procedure opportunity. This new procedure extends the State Hearing to both the beneficiary and the Medi-Cal provider. The adjudication outcomes are:

1. Denial of the beneficiary's reimbursement claim based on failure to provide documentation that meets all adjudication criteria listed in Section F.

    - This outcome generates a NOA and right to a State Hearing for the beneficiary.

2. Tentative reimbursement approval requiring recoupment of a Medi-Cal provider's funds.

    - This outcome generates a NOA and right to a State Hearing for the Medi-Cal provider.

1. Denial of a Claim Based on Failure to Meet All Adjudication Criteria

Claims that fail to provide documentation that meets all adjudication criteria will be denied and a NOA will be sent to the beneficiary. If the beneficiary requests a State Hearing to contest the validity of the denial, a State Hearing will be scheduled.

The hearing will include only the beneficiary and the Department, if the reason for the denial relates only to the beneficiary; i.e., the beneficiary was not eligible for Medi-Cal in the month the services were provided, the service for which reimbursement is requested is not a Medi-Cal benefit, the claim was incomplete, the request for a hearing was filed more than 90 days after the denial NOA was sent.

If the basis of the denial is an issue upon which there could be a dispute between the beneficiary and the Medi-Cal provider, the Medi-Cal provider of the service will be notified that the beneficiary has requested a hearing seeking reimbursement of funds they assert they paid to the Medi-Cal provider for Medi-Cal covered services. The Medi-Cal provider will be informed that if they contest the claim for reimbursement, they must participate in the State Hearing in order to represent their interests. The Medi-Cal provider will be informed that the State Hearing decision will result in a final decision on their obligation to reimburse the beneficiary and failure to represent their interests may subject them to recoupment actions. The Medi-Cal provider will have 30 days from the date of the notification letter to research the case and prepare arguments and evidence.

The Department will prepare a position statement that will set forth the evidence and the Department's determination of the party prevailing on the claim. The hearing will be scheduled with two weeks notice to all parties. All parties wishing to introduce documentary evidence must provide that evidence in advance of the hearing. The SHD will assure that all parties have copies of the documentary evidence prior to the hearing. At the hearing, the Department, the beneficiary, and the Medi-Cal provider will have an opportunity to present testimony and arguments in support of their position and to cross-examine witnesses presented by other parties. At the conclusion of the hearing, the record will be closed and the ALJ will issue a written decision that the parties will receive in the mail.

The rules for State Hearing will follow the regulations set forth in the California Department of Social Services Manual of Policies and Procedures Division 22, to the extent practicable, except as otherwise provided in this Plan.

2. Ensuring Beneficiary Payments through Recoupment of a Medi-Cal Provider's Funds

In the February 8, 2006 court order, the court required the Department to amend the previous implementation plan to provide, "a detailed description of the steps and procedures the Department intends to take to 'ensure payment to a beneficiary by a provider.'" In order to comply, the Department must create a new procedure that may require recoupment of Medi-Cal funds from a Medi-Cal provider that exceed the Medi-Cal rate, if in fact the beneficiary actually paid more for a Medi-Cal covered service than the Medi-Cal maximum rate for that service. The Department has not yet promulgated regulations specific to W&I Code Section 14019.3 defining the specific mechanism to recoup funds from Medi-Cal providers including those in excess of the Medi-Cal rate. This Plan and the subsequent court order in this matter are intended to provide confirmation that the involved department or program responsible for final adjudication of a Beneficiary Reimbursement Claim has the legal authority to implement a monetary recoupment mechanism, to permanently redirect a provider's Medi-Cal reimbursement funds to satisfy an adjudicated Beneficiary Reimbursement claim including the new State Hearing process to provide joint and exclusive administrative remedy to disputes by all involved parties, until such time as the Department promulgates regulations specific to the mechanism of recoupment authorized under California Welfare and Institutions Code Section 14019.3.

The new procedures were designed to assure the beneficiary will receive either full reimbursement, or in the alternative the due process to which they are entitled while also allowing a Medi-Cal provider the right to due process to provide evidence that the proposed reimbursement and recoupment is not correct.

The current State Hearing process for beneficiaries resolves disputes involving any adverse actions related to Medi-Cal eligibility or benefits. That process was enacted pursuant to Welfare and Institutions Code, Section 10950 et. seq. That process is not a remedy for Medi-Cal providers to resolve other Medi-Cal payment/funding issues.

This new State Hearing process includes the following steps:

- The involved department or program will notify the Medi-Cal provider that the involved department or program intends to recoup funds the Medi-Cal provider received from the beneficiary in order to fully to reimburse the beneficiary. The Medi-Cal provider will be informed that it may voluntarily reimburse the beneficiary and bill Medi-Cal for the services rendered, or if it disputes the validity of reimbursement and proposed recoupment, it may request a State Hearing. The involved department or program will receive the Medi-Cal provider's State

Hearing request and forward it to DSS along with information about the beneficiary claim so that DSS can administer the new State Hearing process.

- DSS will send an acknowledgement letter to all parties to the hearing. This letter will inform parties of their right and opportunity to participate in the hearing and that a decision may be made against their interests, even if they do not participate.

- A party will have 30 days to prepare for the hearing after receiving this information. A party may request additional time and upon good cause, SHD will grant additional preparation time.

- The involved department or program will prepare a position statement that explains the reason for the state action and includes all claims documentation timely submitted by the beneficiary and the Medi-Cal provider. The position statement will include the involved department or program's evaluation of the documentation and the involved department or program's proposed disposition of the claim. The position statement will be mailed to the beneficiary and the Medi-Cal provider two weeks before the scheduled hearing.

- The involved department or program, the beneficiary, and Medi-Cal provider will each represent their own interests at the hearing and provide documentation and testimony to support their position. Any party may designate an authorized representative to represent them in accordance with the California Department of Social Services Manual of Policies and Procedures Division 22, as applicable, and guidelines, criteria and information otherwise provided in this Plan.

- All State Hearing decisions resulting in beneficiary reimbursement will be forwarded directly from DSS to the involved department or program for processing of reimbursement if so ordered. (Addresses the February 8, 2006 trial court order, Issue 3.)

The critical steps that distinguish this new State Hearing process from the current process include:

- The new State Hearing process shall jointly provide the beneficiary and the Medi-Cal provider the sole and exclusive administrative remedy regarding their respective interests regarding the claim for reimbursement and the funds potentially subject to recoupment. The State Hearing will afford both the beneficiary and the Medi-Cal provider the opportunity to present evidence, through documents and/or testimony, to challenge any evidence presented against them, and to present arguments for their position. The beneficiary, Medi-Cal provider, and involved department or program are all parties to the State Hearing.

- A Medi-Cal provider will be permitted 30 days from the date of the NOA regarding the intended recoupment action to request a State Hearing to contest the recoupment of Medi-Cal funds. If the court determines a longer period is required, the time within which the beneficiary's claim will be adjudicated must be extended by the same number of days.

- A State Hearing to determine the correctness of the involved department or program determination regarding the reimbursement claim and recoupment action may be held by telephone, unless in the discretion of the ALJ, the interests of justice require a videoconference or in person hearing. The primary relevant evidence in these cases will be documents, and all parties will have all evidence in hand at the time of the hearing.

- A postponement or continuance of the State Hearing granted to one party will extend, by an equal number of days, the date by which a final decision to all parties is due in the case.

- A request for a State Hearing tolls the beneficiary's 120-day payment timeline for reimbursement of a completed claim to determine if evidence submitted by the Medi-Cal provider rebuts the beneficiary claim.

- A requirement that both the Medi-Cal provider and the beneficiary must agree to withdraw a hearing request and if one party disagrees, the State Hearing will proceed.

- The Medi-Cal provider may authorize a "designated hearing representative" to present their evidence; this may be an attorney, employee of their practice/company, or anyone else.

- The SHD shall have the authority to adopt such other procedures and process as are advisable or required for the conduct and adjudication of the beneficiary reimbursement State Hearings by All County Letter (ACL.) Any ACL setting forth SHD procedures for beneficiary reimbursement hearings shall have the force and effect of law from the time the ACL is issued for 30 months. At the end of that period, the SHD must adopt regulations setting forth the procedures and processes for the beneficiary reimbursement hearings.

The Medi-Cal provider and the beneficiary will have the joint and exclusive opportunity to have the matter adjudicated by an ALJ. At the hearing evidence will be taken and discretion in the determination of facts will be vested in the ALJ. After the record is closed the ALJ shall issue an administrative decision. The reimbursement and recoupment process will be stayed pending the outcome of the State Hearing. Any appeal of the final decision by the beneficiary and/or the Medi-Cal provider shall proceed under California Code of Civil Procedure, section 1094.5.

The involved department or program may implement this new procedure through the establishment of guidelines, criteria and information bulletins published in Medi-Cal Provider Manuals, Medi-Cal Provider Bulletins, ACL, Beneficiary Notices, and Medi-Cal beneficiary publications. Pursuant to W&I Code, section 14019.3(j), "Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code, this section may be implemented with a provider bulletin or similar notification, without any further regulatory action."

EXHIBIT B

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

IF YOU WERE ELIGIBLE FOR MEDI-CAL ANYTIME SINCE JUNE 27, 1997, OR ARE ELIGIBLE NOW

MEDI-CAL MAY REIMBURSE YOU FOR MEDICAL OR DENTAL BILLS YOU PAID

Conlan v. Bontá; Conlan v. Shewry

As the result of two court decisions, you may be able to be repaid for some medical expenses you paid. The California Department of Health Services (CDHS) will assist you in getting your money back if all criteria below are met:

1. You received a medically necessary medical or dental service during one or all of these time periods:
   - ✓ The 3-month period prior to the month you applied for the Medi-Cal program;
   - ✓ From the date you applied for the Medi-Cal program until the date your Medi-Cal card was issued,
   - ✓ After your Medi-Cal card was issued (includes excess co-payment and excess share of cost charges), and
2. You paid for your medical or dental service; or another person paid for your medical or dental service on your behalf. You will be asked to provide proof that the medical or dental service was paid for by you or the other person, and
3. You received the medical or dental service from a Medi-Cal enrolled provider (note: you do not need to have received the service from a Medi-Cal enrolled provider if you received the medical or dental service during the 3-month period prior to applying to Medi-Cal, or you received the services on or after June 27, 1997 but before February 2, 2006 and you had applied for Medi-Cal but not yet received a Medi-Cal card), and
4. For those Medi-Cal services that were provided and would have required Medi-Cal authorization, you have documentation from the medical or dental provider that shows medical necessity for the service, and
5. You were Medi-Cal eligible to receive that specific medical or dental service, and
6. The medical or dental service was a benefit under the Medi-Cal program, and
7. The medical or dental service was provided on or after June 27, 1997, and
8. After you received your Medi-Cal card, you contacted your provider and showed your provider your Medi-Cal card and the provider would not give you your money back.

Important dates and time frames:

- For services received June 27, 1997 through Month Day, Year[pf1], you must submit your claim by Month Day, Year [pf2]or within 90 days after issuance of the Medi-Cal card, which ever is longer.
- For services received on or after Month Day, Year[pf3],, you must submit your claim within one year of receipt of services or within 90 days after issuance of the Medi-Cal card, which ever is longer.

For more information or to file a claim, you MUST call or write to Medi-Cal at:

For Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Services Claims:	**For Dental Claims:**
California Department of Health Services Beneficiary Services P.O. Box 13008 Sacramento, CA 95813-9998 **(916) 403-2007 TDD: (916) 635-6491**	Denti-Cal Beneficiary Services P.O. Box 15539 Sacramento, CA 95852-1539 **(916) 403-2007 TDD: (916) 635-6491**

-- DON'T FORGET TO KEEP ALL RECEIPTS FOR THE MEDICAL AND DENTAL CARE YOU RECEIVE --

Medi-Cal will review your claim for repayment and send you a letter with a check or a denial letter that tells you the reason for denial. If Medi-Cal denies your request for payment, you may ask for a fair hearing. The denial letter will tell you how to ask for a fair hearing.

Medicare/Medi-Cal Coverage: Starting January 1, 2006, medications covered under Medicare Part D will not be a covered benefit under the Medi-Cal Program and are not eligible for reimbursement. For questions regarding Medicare Part D contact 1-800-Medicare.

SI USTED ERA ELEGIBLE PARA MEDI-CAL EN CUALQUIER MOMENTO DESDE EL 27 DE JUNIO DE 1997, O AHORA ES ELEGIBLE, ES POSIBLE QUE MEDI-CAL LE REEMBOLSE POR CUENTAS MÉDICAS O DENTALES QUE USTED HAYA PAGADO

Conlan v. Bontá; Conlan v. Shewry

Como resultado de dos decisiones de la corte, es posible que usted pueda ser reembolsado/a por algunos costos médicos que usted pagó. El Departamento de Servicios de Salud de California (California Department of Health Services-CDHS) le asistirá en conseguir el reembolso de su dinero si satisface todos los requisitos mencionados abajo:

1. Usted recibió un servicio médico o dental que fue médicamente necesario durante uno o todos estos períodos:
   - ✓ En el período de 3 meses antes del mes que usted solicitó para el programa de Medi-Cal;
   - ✓ A partir de la fecha que usted solicitó para el programa de Medi-Cal hasta que su tarjeta de Medi-Cal fue expedida,
   - ✓ Después de que se expida su tarjeta médica (incluye exceso del co-pago y exceso de cargos de parte del costo, y
2. Usted pagó por su servicio médico o dental; o
   otra persona pagó por su servicio médico o dental de parte de usted (le pedirán proveer la prueba del servicio médico o dental que fue pagado por usted o por la otra persona, tal como un recibo o un cheque cancelado con una lista detallada de los servicios cubiertos por el pago), y
3. Usted recibió el servicio médico o dental de un proveedor inscrito en Medi-Cal (nota: usted no necesita haber recibido el servicio de un proveedor inscrito en Medi-Cal si usted recibió el servicio médico o dental durante el período de tres meses antes de solicitar Medi-Cal), y
4. Usted tiene una receta médica, orden o nota de un proveedor médico o dental, o evaluación de sus necesidades del programa Servicios de Casa y Cuidado Personal (In-Home Supportive Services) del condado por el servicio médico o dental que usted recibió y cuál usted pagó (a excepción de una visita de oficina con el médico/dentista, que no requiere una receta médica), y
5. Usted tenía elegibilidad de Medi-Cal para recibir ese servicio especifico médico o dental, y
6. El servicio médico o dental fue un beneficio bajo el programa de Medi-Cal, y
7. El servicio médico o dental fue proporcionado en o después del 27 de junio de 1997, y
8. Después de que usted recibió su tarjeta de Medi-Cal, usted contactó a su proveedor y le demostró a su proveedor su tarjeta de Medi-Cal y el proveedor no le reembolsó su dinero.

Fechas y marcos de tiempo importantes:

- Para los servicios recibidos el 27 de junio de 1997 al ~~30 de septiembre del 2006~~, usted debe presentar su reclamo antes del ~~1º de octubre del 2007~~, o en el plazo de 90 días después de que se expida la tarjeta de Medi-Cal, cualquier plazo que sea el más largo.
- Para los servicios recibidos en o después del ~~1º de octubre del 2006~~, usted debe presentar su reclamo dentro del plazo de un año de la fecha que recibió los servicios, o en el plazo de 90 días después de que se expida la tarjeta de Medi-Cal, cualquier plazo que sea el más largo.

Para más información o presentar un reclamo, usted DEBE llamar o escribir a Medi-Cal al:

Para Reclamos Médicos, de Salud Mental, de Drogas y Alcohol, y de Servicios de Casa y Cuidado Personal (Medical, Mental Health, Drug and Alcohol, and In-Home Supportive Service Claims): California Department of Health Services Beneficiary Services P.O. Box 13008 Sacramento, CA 95813-9998 **(916) 403-2007 TDD: (916) 635-6491**	**Para Reclamos Dentales (Dental Claims):** Denti-Cal Beneficiary Services P.O. Box 15539 Sacramento, CA 95852-1539 **(916) 403-2007 TDD: (916) 635-6491**

--NO SE OLVIDE DE GUARDAR TODOS LOS RECIBOS DEL CUIDADO MÉDICO Y DENTAL QUE USTED RECIBE--

Medi-Cal revisará su reclamo para el reembolso y le enviará una carta con un cheque o una carta de negación que le explicará la razón del porqué fue negado/a. Si Medi-Cal niega su pedido de pago, usted puede pedir una audiencia justa. La carta de negación le dirá cómo pedir una audiencia justa.

Cobertura de Medicare/Medi-Cal: Empezando el 1º de enero del 2006, las medicaciones cubiertas bajo Medicare Parte D no serán un beneficio cubierto bajo el programa de Medi-Cal y estas medicaciones no son elegibles para el reembolso. Para las preguntas con respecto a Medicare Parte D llame al 1-800-Medicare.

DECLARATION OF SERVICE BY U.S. MAIL

Case Name: **Kevin Conlan, Asher Schwarzmer, et al. v. DHS**

No.: . **987697**

I declare:

I am employed in the Office of the Attorney General, which is the office of a member of the California State Bar, at which member's direction this service is made. I am 18 years of age and older and not a party to this matter. I am familiar with the business practice at the Office of the Attorney General for collection and processing of correspondence for mailing with the United States Postal Service. In accordance with that practice, correspondence placed in the internal mail collection system at the Office of the Attorney General is deposited with the United States Postal Service that same day in the ordinary course of business.

On , October 27, 2006 I served the attached **RESPONDENTS' REPLY TO PETITIONERS' REMAINING OBJECTIONS TO RESPONDENTS' REVISED PLAN AND NOTICE** by attaching a true copy, which has been converted into an Adobe Acrobat .pdf file, to an email message and sending the message electronically to the email addresses listed below. In addition I served the attached document by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the internal mail collection system at the Office of the Attorney General at 455 Golden Gate Avenue, Suite 11000, San Francisco, CA 94102-7004, addressed below as follows:

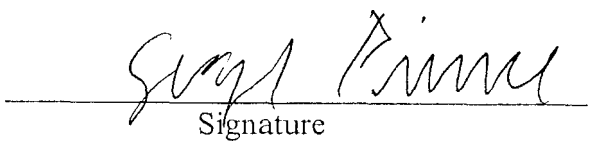
Michael Keys
Bay Area Legal Aid
50 Fell Street, First Floor
San Francisco, CA 94102
MKeys@baylegal.org

Richard A. Rothschild, Esquire
Western Center on Law and Poverty
3701 Wilshire Boulevard, Suite 208
Los Angeles, CA 90010-2809
RRothschild@wclp.org

Barbara K. Frankel, Esq.
Neighborhood Legal Services
of Los Angeles County
13327 Van Nuys Boulevard
Pacoima, CA 91331-3099

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on October 27, 2006, at San Francisco, California.

George Prince
Declarant


Signature

40114401.wpd